**Wisconsin Shares Parent Medical Exemption**

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

**Use of form:** This form is to be used for two-parent households or three-generation households where the one parent has a disability or health condition that makes that parent unable to care for the child(ren) **and** unable to participate in an approved activity as is required for the Wisconsin Shares Child Care Subsidy. Parents must provide documentation of the disability or health condition from a doctor, physician assistant, nurse practitioner, psychiatrist, or psychologist [Wis. Admin. Code DCF § 201.039(4)(a)].

This form is voluntary. The required information can be provided by the doctor, physician assistant, nurse practitioner, psychiatrist, or psychologist on medical facility letterhead or an email directly from the provider.

**Instructions:**

1. Use blue or black ink.
2. Do not write in shaded areas.
3. Return this form to your local agency in person, by fax, or by mailing to the address provided in **the Local Agency Information** section. You can also have the doctor, physician assistant, nurse practitioner, psychiatrist, or psychologist fax, email, or mail it to the agency for you.

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| **Local Agency Information** | | |
| Agency staff completes this section | | |
| Local Agency Name | | Telephone Number |
| Local Agency Address (Street, City, Zip Code) | | Fax Number |
| Date this completed form is received at the local agency | RFA / Case Number | |

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| **Parent Contact information** | | | | |
| Complete this information and bring this to the medical health professional that can verify your disability or health condition. Once the form has been signed by the health care professional, return this to your local agency. | | | | |
| Parent Name | | Date of Birth | | Telephone Number |
| Home Address | | | | |
| City | | State | | Zip Code |
| **Medical Information** | | | | |
| Health care provider completes the required medical information below. | | | | |
| This parent is unable to (check all that apply):  Care for their child(ren)  Participate in an approved activity\* | | | | |
| \*All parents must participate in an approved activity to receive child care subsidies. Approved activity means employment, education or other activities that will lead to work. | | | | |
| The condition is:  Permanent  Temporary | | | | |
| If the condition is temporary, enter the timeframe the parent is expected to be unable to participate in an approved activity and unable to care for their child(ren). | | | | |
| Begin Date | End Date | | | |
| Medical condition verified by: | | | | |
| Health Care Provider Name (print) | | | | |
| Health Care Provider Address | | | | |
| City | | | State | Zip Code |
| Qualifications:  Medical Doctor  Nurse Practitioner  Licensed Psychologist  Physician Assistant  Licensed Psychiatrist  Other – Specify: | | | | |
| Notes / Comments | | | | |
| Health Care Provider Signature | | | | Date Signed |